Copies of desk review work papers will be furnished to the provider upon written request. The provider will be charged the usual and customary charge for photocopying. Facilities have the right of appeal as described in Section 1-7 of this plan.

The desk review procedures will consist of the following:

1. Cost reports will be reviewed for completeness, accuracy, consistency and compliance with the Mississippi Medicaid State Plan and Division of Medicaid policy. All adjustments (whether in the provider's favor or not) will be made, if necessary. All adjustments will include written descriptions of the line number on the cost report being adjusted, the reason for the adjustment and the amount of the adjustment, and the applicable section of the State Plan or the Medicare HCFA-15 Manual that is being used to justify the change.
2. The cost report will be compared with the prior year cost report and the prior year audit, if applicable, for consistency. Any material variations from costs reported for the previous year will be investigated. Providers

may be requested to submit additional information prior to the completion of the desk review.

3. All desk review findings will be sent to the provider or its designated representative.

J. Audits of Financial Records

The Division of Medicaid or its contract auditors will conduct audits to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost report. Audits will be performed each year on at least twenty-five percent (25%) of the long-term care facilities certified for Title XIX. At least five percent (5%) of the long-term care facilities will be randomly selected. Each facility will be audited at least once every four (4) years. Facilities will be selected for audit for the initial cost report after enrollment in the Medicaid program, after a change of ownership, or after a change of classification. There will be no audit of the final cost report of the seller due to a

change of ~~ownership~~. Since the prior reimbursement plan did not ~~require~~ an audit of each facility at least once every four (4) years, ~~this~~ requirement will be phased in so that by December 31, 1995, this requirement will have been met.

Audit adjustments (whether in the provider's favor or not) will be made, if necessary. All adjustments will include written descriptions of the line number on the cost report being adjusted, the reason for the adjustment and the amount of the adjustment, and the applicable section of the State Plan or HIM-15 that is being used to justify the change.

K. Record Keeping Requirements

Providers must maintain adequate financial records and statistical data for proper determination of costs payable under the program. The cost report must be based on the financial and statistical records maintained by the facility. All non-governmental facilities must file cost reports based on the accrual method of accounting. Governmental facilities have the option to use the cash basis of accounting for reporting. Financial and statistical data must be current, accurate and in sufficient detail to support costs contained in the cost report. This includes all ledgers,

books, records and original evidence of cost (purchase requisitions for supplies, invoices, paid checks, inventories, time cards, payrolls, basis for allocating costs, etc.) which pertain to the determination of reasonable costs. Statistical data should be maintained regarding census by payment source, room numbers of residents, hospital leave days and therapeutic leave days.

Financial and statistical records should be maintained in a consistent manner from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures, provided that full disclosure of significant changes are made to the Division of Medicaid and its fiscal agent audit department. This disclosure should be made as a footnote on the cost report and should include the effect of the change.
All financial and statistical records, including cost reports, must be maintained for a period of five (5) years after submission to the Division of Medicaid.

A provider must make available any or all financial and statistical records to the Division of Medicaid or its contract auditors for the purpose of determining compliance with the provisions of this plan or Medicaid policy.

L. Failure to File a Cost Report

Providers that do not file a required cost report within six (6) months of the close of the reporting period will have their Medicaid Provider Agreement terminated.

M. Change of Ownership

For purposes of this plan, a change of ownership of a facility includes, but is not limited to, inter vivos gifts, purchases, transfers, lease arrangements, cash and/or stock transactions or other comparable arrangements whenever the person or entity acquires a majority interest of the facility. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer - seller relationship.

Costs attributable to the negotiation or settlement of the sale or purchase of any capital asset whether by acquisition or merger for which any payment has previously been made shall not be considered reasonable in the provision of health care services and, therefore, shall not be included in allowable costs. These costs include, but are not limited to, legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies.

Facilities which undergo a change of ownership must file a cost report from the date of the change of ownership through the end of the third month of ownership. The Division of Medicaid may shorten or lengthen the reporting period of the initial cost report to not less than one (1) month or not more than four (4) months. Facilities will be paid the maximum per diem rate for their classification until the rate is adjusted based on this initial cost report. The maximum per diem rate is defined as the maximum base rate for direct care and care related costs, allocated between the two cost centers based on the cost report filed by the previous owner that was used to compute the rate in effect on the date of the change of ownership, and adjusted for the case mix of the previous owner for the appropriate calendar quarter, plus the ceiling for administrative and operating costs, plus the gross rental per diem payment computed under the fair rental system as defined by this plan. The new owner will not receive a return on equity capital per diem or a property tax and insurance per diem until the initial cost report is filed. The rate computed based on the initial cost report of the new owner will be effective the same date the change of ownership was effective.

The seller must file a final cost report with the Division of Medicaid from the date of the last cost report to the effective date of the sale.

A facility which undergoes a change of ownership must notify the Division of Medicaid in writing of the effective date of the sale. The seller's provider number will be closed and a new provider number assigned to the new owner after the new owner submits the provider enrollment information required under Division of Medicaid policy. The new owner is not allowed to use the provider number of the old owner to file claims for reimbursement.

For sales of assets finalized on or after July 1, 1993, there will be no recapture of depreciation.

N. Increase or Decrease in Number of Medicaid Certified Beds

Facilities which either increase or decrease the number of certified beds by less than one-third (1/3) the current number of certified beds will not be required to file a short-period cost report and will not have the per diem rate changed unless the increase or decrease in the number of certified beds results in a

change of classification. Facilities which either increase or decrease by one-third (1/3) or more the number of certified beds than the current number of certified beds must file a cost report from the effective date of the increase or decrease in the number of certified beds through the end of the third calendar month following the effective date of the increase or decrease. The Division of Medicaid may shorten or lengthen the reporting period of the initial cost report to not less than two (2) months or not more than four (4) months. These facilities must also file a cost report for the period starting the date of the last cost report to the effective date of the increase or decrease in the number of beds that results in a change of more than one-third the number of certified beds.

O. New Providers

Nursing Facilities and ICF-MR's beginning operations during a reporting year will file an initial cost report from the date of certification to the end of the third (3rd) month of operation. The Division of Medicaid may lengthen the reporting period of the initial cost report to not more than six (6) months. Facilities will be paid the maximum rate for their classification until the initial cost report is received and the rate is calculated. The maximum rate for nursing facilities is defined as the ceiling for direct care and care related costs paid based on a case mix of 1.00

plus the ceiling for administrative and operating costs and the gross rental per diem payment as computed under the plan. The maximum rate for ICF-MR's and PRTF's is defined as the ceiling for direct care, therapies, care related, administrative and operating plus the gross rental per diem as computed under the plan. New facilities will not be paid a return on equity per diem or a property tax and insurance per diem until the initial cost report is filed. A retroactive rate adjustment to the initial certification date will be made after the receipt and desk review of the initial cost report using the base rate computed and the applicable facility-average case mix score(s). For example, a new nursing facility provider enrolls in the Medicaid program effective August 15, 1993. The facility initially would be paid the maximum rate for their classification as defined above. The direct care and care related payment would be based on a case mix of 1.00. After the case mix score is computed for the period August 15, 1993 through September 30, 1993, it is determined that the actual average case mix was 1.15. The facility would have their rate adjusted for the period August 15, 1993 through September 30, 1993 based on the case mix score of 1.15 and based on their actual cost on the initial cost report of the facility. The administrative and operating per diem payment and the property taxes and insurance per diem payment would be based on

reported cost. And the per diem return on equity payment would be based on reported balances. In addition, the facility's rates for the calendar quarters ended December 31, 1993 and March 31, 1994 would be based on the case mix score determined for the period August 15, 1993 through September 30, 1993.

A retroactive rate adjustment, effective the date of certification, will be made for ICF-MR's based on the initial short period cost report.

PRTF's beginning operations during a reporting year will file a cost report from the date of certification to the end of the sixth (6th) month of operation. Facilities will be paid the maximum rate for their classification until the six (6) month cost report is received and the rate is calculated. A retroactive rate adjustment will be made based on the six month cost report effective the date of certification.

P. Out-of-State Providers

Nursing Facilities, PRTF's and ICF-MR's from states other than Mississippi may file claims for services provided to Mississippi Medicaid recipients that are